MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Oxymed, Inc. 3820 W. NW. Highway, Suite 215 Dallas, Texas 75220	MDR Tracking No.: M4-03-A442-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company Box 54	Date of Injury: Employer's Name: Insurance Carrier's No.: 01C1232715

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
03/06/03	03/06/03	E1399	$23.25	$23.25
03/06/03	03/06/03	E1399	$11.25	$11.25
03/06/03	03/06/03	E0114	$69.50	$69.50
03/07/03	03/07/03	E0781	$72.75	$72.75

PART III: REQUESTOR'S POSITION SUMMARY

"Our charges were billed consistently with the medical policies and fee guidelines as established by the commission. There is a letter of medical necessity, an Operative report and a signed prescription attached form the patient's treating doctor…"

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier did not submit a response. Denials listed on the EOB state, "Reimbursed to fair and reasonable. Allowance for this procedure was made at the 'Fair and reasonable' amount for this geographical area."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The provider submitted product information and redacted EOBs from various insurance carriers indicating what they had paid. The information provided indicates that the carriers had reimbursed the full amount the provider billed 133.307(g)(3)(D). No other denials were noted in the claim file. Therefore, based on the information provided additional reimbursement is recommended.

PART VI: DETAIL FINDINGS (If needed)

				Total Left Column:			$0.00
				Total Amount Due:			$176.75

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled reimbursement in the amount of **$176.75**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the requestor within 20-days in receipt of this Order.

Ordered by:

	Michael Bucklin	01/10/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____